Nova In Vitro Fertilization

Comprehensive Medical History Form

Date:_____

Who referred you to our practice?

- ☐ Former Patient
- ☐ Friend
- ☐ SART Data
- ☐ Self-referral
- ☐ Yelp
- ☐ Physician - please list name:
- ☐ Internet Search- please specify what search terms:

Reason for consultation: _____
_____

What are your goals or expectations for your consultation? _____
_____

Patient Demographic Information

	Patient	Partner
Name:		
Date of Birth:		
Occupation:		

Current weight:_____pounds Height:___feet_____inches

Ethnicity:
- ☐ White
- ☐ Hispanic or Latino
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific
- ☐ Asian
- ☐ Other:_____
- ☐ Decline to answer

Fertility History:

Duration of relationship:_____years and_____months

Duration of unprotected intercourse:___years and_____months

How long have you been actively attempting pregnancy?_____years and_____months

How frequently do you and your partner have intercourse?_____per week /_____per month

Have you ever used a method to keep you from getting pregnant? ☐ Yes ☐ No

If yes, what method(s)?_____

If known, what is the cause of your infertility?_____
_____

Pregnancy history (Patient):

Pregnancy	1st	2nd	3rd	4th
Mo/Yr of conception				
How long did it take to conceive?				
Infertility treatment? (Y/N)				
Did your current partner sire the pregnancy?				
Outcome (vaginal delivery, cesarean, ectopic, miscarriage, termination				
Live birth > 37 weeks? (Y/N)				
Other pregnancy complications?				

How old were you when your periods first started? _____ years

Did you develop regular monthly periods at that time? ☐ Yes ☐ No

Do you have monthly menstrual periods now? ☐ Yes ☐ No

If yes, what is the usual number of days between the start of one period to the start of the next period? _____ days

Dates of the 1st day of your last 2 menstrual periods: ___/___/___ ___/___/___

How many menstrual periods do you have per year? _____

Do you have severe cramping or pelvic pain with your menstrual periods? ☐ Yes ☐ No

Do you have pain with intercourse? ☐ Yes ☐ No

Have you been diagnosed with endometriosis? ☐ Yes ☐ No

Have you ever had a pelvic infection? ☐ Yes ☐ No

Have you been diagnosed with any health problems? ☐ No ☐ Yes (explain)

_____

_____

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

- ☐ Hepatitis
- ☐ Chlamydia
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Herpes
- ☐ Genital Warts/HPV

Please complete the following table as accurately as possible, especially the "Physician/Clinic" column.

Test	Date(s)	Physician/Clinic	Results/Findings
Thyroid Test (TSH)			
Day 3 blood test for FSH & Estrogen			
AMH			
Prolactin level			
Hysterosalpingogram (X-Ray of Tubes/HSG)			
Sonohysterography (water ultrasound)			
Hysteroscopy			
Genetic Testing			
Endometrial receptivity testing			

Health care maintenance:

When was your last pap smear (month/year)? ___ /_____ ☐ Normal ☐ Abnormal

When was your last abnormal pap smear? ___ /_____ ☐ Not applicable

Do you perform self breast exams? ☐ Yes ☐ No

Have you ever had a mammogram? ☐ Yes ☐ No

When was your last mammogram?_____month_____year ☐ Normal ☐ Abnormal

Medications/Supplements:

Are you allergic to any medications? ☐ No ☐ Yes:_____

Are you currently taking any medications or supplements?

If yes, please list below:

Medication/Supplement	Start Date	Dose

Surgical history:

Please list any surgeries you have had in chronological order:

Year	Reason and Type of Surgery

Social History:

How many caffeinated beverages (coffee, soda, tea) do you drink per day? _____

On average how much water are you consuming daily? _____

Do you exercise regularly? ☐ Yes ☐ No
If yes, describe: _____

Do you smoke cigarettes or have you ever used tobacco products? ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No

Have you ever used illicit drugs? ☐ Yes ☐ No

Are you allergic to any foods? ☐ Yes ☐ No
If yes, describe: _____

Have you had significant weight change in the last year? ☐ Yes ☐ No

Emotional Status:

On a scale of 1-10 (10 being the worst), estimate the level of stress you feel due to infertility and other pressures: _____

Do you see a counselor? ☐ Yes ☐ No

List any anti-depressant/anti-anxiety medication you are currently taking: _____

Has your infertility produced marital or sexual dysfunction? ☐ Yes ☐ No

Family History:

Have any of these illnesses occurred in your family:

☐ High blood pressure ☐ Breast cancer ☐ Infertility
☐ Diabetes ☐ Ovarian cancer

Immunization History:

Chickenpox (Varicella): ☐ No ☐ Yes (dates:) ☐ Don't Know

MMR- Measles, Mumps, Rubella (German Measles): ☐ No ☐ Yes (dates:) ☐ Don't Know

Tetanus (Tdap): ☐ No ☐ Yes (dates:) ☐ Don't Know

Hepatitis B: ☐ No ☐ Yes (dates:) ☐ Don't Know

Polio: ☐ No ☐ Yes (dates:) ☐ Don't Know

Influenza: ☐ No ☐ Yes (dates:) ☐ Don't Know

Covid-19: ☐ No ☐ Yes (dates:) ☐ Don't Know
☐ Moderna ☐ Pfizer ☐ Johnson & Johnson ☐ Other_____

Prior Infertility Treatment (please indicate which **medication** if applicable):

Treatment	# of Cycles	Dates: From (Mo/Yr) / To (Mo/Yr)	Outcome
☐ Clomid or Femara / Letrozole with timed intercourse			
☐ Clomid or Femara / Letrozole with insemination (IUI)			
☐ Injectable medications with insemination (IUI)			
☐ Intrauterine insemination (IUI) alone-natural cycle			

In Vitro Fertilization Treatment History

Treatment	Cycle 1	Cycle 2	Cycle 3	Cycle 4
Cycle date				
IVF center/physician				
Maximum gonadotropin dose (Follistim, Gonal-F, Menopur)				
# Eggs retrieved				
Was ICSI performed? (Y/N)				
# Eggs fertilized				
#Eggs/embryos frozen				
Was genetic testing performed on the embryos?				
Did an embryo transfer take place in a fresh or frozen cycle?				
How many embryos transferred?				
Embryo age (day 2, 3, 5)				
Outcome				

Partner History:

Partner: pregnancies from previous marriage(s) or partner(s):

Pregnancy	1st	2nd	3rd	4th
Mo/Yr of conception				
How long did it take to conceive?				
Gender				
Outcome	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion	☐ Living ☐ Miscarriage ☐ Ectopic ☐ Abortion

Have you ever been evaluated by a urologist? ☐ Yes ☐ No

Do you have difficulty with erections? ☐ Yes ☐ No

Do you have retrograde ejaculation of sperm into the bladder? ☐ Yes ☐ No

Have you ever had any of the following sexually transmitted diseases or pelvic infections?

- ☐ Chlamydia
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Hepatitis
- ☐ Genital Warts/HPV

Do you have a history of undescended testicles? ☐ Yes ☐ No

Do you have scrotal or testicular pain? ☐ Yes ☐ No

Have you had prior injury to your testicles requiring hospitalization? ☐ Yes ☐ No

Have you had a high fever in the last 3 months? ☐ Yes ☐ No

Have you had a vasectomy? ☐ Yes ☐ No

Have you had surgery for varicocele repair? ☐ Yes ☐ No

Have you had hernia surgery? ☐ Yes ☐ No

Did you undergo any bladder or penis surgery as a child? ☐ Yes ☐ No

Are you exposed to any radiation or harmful chemicals in the workplace? ☐ Yes ☐ No

Have you had chemotherapy for cancer? ☐ Yes ☐ No

Have you ever used testosterone, androgel or androgenic hormones? ☐ Yes ☐ No

Have you been diagnosed with any health problems? ☐ No ☐ Yes (explain)

_____

_____

Please complete the following table as accurately as possible, especially the "Physician/Clinic" column.

Test	Date(s)	Physician/Clinic	Results
Semen Analysis			
Chromosomes (karyotype)			
Genetic Testing			

Medications/Supplements:

Are you allergic to any medications? ☐ No ☐ Yes:_____

Are you currently taking any medications or supplements?

If yes, please list below:

Medication/Supplement	Start Date	Dose

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